Rhode Island Arthritis Action Plan 2001-2005

State of Rhode Island
Department of Health

Patricia A. Nolan, MD, MPH
Director of Health

Donald L. Carcieri
Governor

Rhode Island Arthritis Action Plan 2001-2005

Rhode Island Department of Health
Arthritis Action Program
3 Capitol Hill, Room 409
Providence, Rhode Island 02908
Phone: (401) 222-1383
Fax: (401) 222-4415
Hearing/Speech Impaired, Dial 711
or call 1-800-745-5555 (TTY)
www.health.ri.gov

This document was created with support from the Centers for Disease Control and Prevention (CDC), Chronic Disease Prevention and Health Promotion Programs, Cooperative Agreement Number U58/CCU120281-02

Participants of the 2001 State Arthritis Action Plan

Roy Aaron MD
Orthopedic Associates

Jim Agostinucci, ScD, OT
Physical Therapy Program
URI

Bobbie Houllahan
Neighborhood Minority Health Promotion Center

Bonnie Alderman
North Bay Manor

Lori Almeida
Urban League of Rhode Island

Jill Anderson
Senior Services Inc.

Susan Andrews
Arthritis Foundation

Beth Andrews
United Health Care of New England

Bethany Atkins, PT
KMH

Eddie Beard
Providence Recreation Department

Karen Beauchene
Cornerstone Adult Services

William Beaulieu, RPh
Pharmacy Outreach Program

Peter R. Blanpied, PhD
University of Rhode Island

Helen Mary Borgus
Scleroderma Support Group

James Burrill, MD
Landmark Senior Health

Mary Lou Buyse, MD
United Health Care of New England

Kathleen Carland
Beechwood House Senior Center

Linda Carney
Landmark Medical Center

Terry Carr
Governor's Commission on Disabilities

John Carroll
Arthritis Foundation

Paul Choquette
PARI

Phillip Clark, PhD
University of Rhode Island

Catherine Cochran
Arthritis Foundation

Max Cohen
Arthritis Foundation

Elaine Collins Genari
RI State Nurses Association

David Cournoyer, Jr.
Providence Recreation Department

Carol Cowell
Scleroderma Association

Paul Davis
Blue Cross of Rhode Island

Tracie DelSesto
Rehabilitation Hospital of RI

Elizabeth Demers
RI Chapter of The American Physical Therapy Association

Katie DiMeo
Warwick Public Library

Marianela Dougal
Westminster Senior Center

Sharon Dubois-Hall
Rhode Island Department of Health

Patricia Durfee
Support Staff, Inc.

Faiza Fawaz Estrup, MD, PhD
Memorial Hospital of RI

Sharon Fennell
Westminster Senior Center

Dorothy Finnegan
St Martin de Porres Senior Center

Donald Fowler
RI Pharmacists Association

John Froehlich, MD
University Orthopedics

Cathy Gaffney
Arthritis Foundation

Dale Greer
Neighborhood Health Plan of RI

Kathy Gremel RN, MS
Neighborhood Health Plan

Larry Grimaldi
Department of Elderly Affairs

Laurence P. Hall
Support Staff, Inc.

Pamela Haskell
Senior Center Association

Marilyn Heller
Portsmouth Senior Center

Kathy Hollis
American Baptist Church of RI

Peter Hollman, MD
Blue Cross of Rhode Island

Harold Horwitz, MD
Rheumatology Association

Wayne Houle, Sr.
St. Martin de Porres Senior Center

Maryanne Hurley, FNP
RI Nurse Practitioner Council

Jesse Jordan, MD
Urban League of Rhode Island

Anthony Kazlauskas, MD
United Health Care of New England

Ann Kelsey Thacher, MS
Rhode Island Department of Health

Hanna Kim, PhD
Rhode Island Department of Health

Jane King
OSCIL

Leslie Kotke
Southern New England Chapter

Sandra Kristiansen, MD
Rheumatologist

Hartley LaCorbinniere
Lupus Foundation of America

Lisa LaDew
Rehabilitation Hospital of RI

Edward Lally, MD
Rheumatologist

Kelley Lee, MS
Day Care Association

Jean Lepore
Arthritis Foundation

Bob Henry
Rhode Island Assisted Living Association

Paulla Lipsey
Department of Elderly Affairs

Sharon Marable, MD, MPH
Rhode Island Department of Health

Tomas Avila
Progresso Latino

Rebecca Martinique
Arthritis Foundation Southern NE Chapter, RI Branch

Helen McCarthy -Deines
Rhode Island Meals on Wheels

Pamela McCue
RI State Nurses Association

DeDe McGuire
Care New England

Kathleen McKeon
Department of Elderly Affairs

Kathleen McNamee
Buttonwoods Center

Kathleen Meleney, RN
Narragansett Indian Health Center

Cheryl Michaud
Scleroderma Support Group

John Mukand, MD
Southern NE Rehabilitation Center

Heidi Niederberger, SW
Kent Hospital

Madeline O'Connell
Arthritis Foundation

Mary Lou Palumbo
Cox Communications

Jeanne Panarace
Rhode Island Department of Health

Barbara Miller Perry
Rhode Island Quality Partners

Marcia Petrillo
Rhode Island Quality Partners

Edna Poulin
Rhode Island Department of Health

Pamela Reardon
Cornerstone Adult Services

Lorna Ricci
Ocean State Center for Independent Living

Susan Richer
Greater Providence YMCA

Jerrold Rosenberg, MD
Physical Medicine & Rehabilitation

Heidi Roynestad OT
RI Occupational Therapist Association

Renee Rulin, MD, MPH
Neighborhood Health Plan of RI

Richard Ryan
Day Care Association

Ann Marie Sepe, RN
Occupational Nurses Association

Kathleen M. Sloane, RN, MS
The Rehabilitation Center at Kent

William Speck
Seniors Ask

John Stokiedes, MD
RW Senior Healthcare Associates

Karen Testa
Salvatore Mancini Center on Aging

Anne Marie Torres
Cranston Senior Center

Sreekala Vasudevan, MD
Prov Community Health Centers, Inc.

Marcia Weiss RN, MS
Lifespan

Edward Westrick, MD
RI Quality Partners

Sharon Wolff
Case Management of MOW

Edward Zesk
Aging 2000

Bernard Zimmerman, MD
Rheumatologist

Dedication

Sharon E. Dubois-Hall
November 20, 1957 – March 7, 2002

This publication is dedicated to the memory of Sharon E. Dubois-Hall, Rhode Island's first Arthritis State Program Coordinator. Sharon was instrumental in bringing together Rhode Islanders from many different venues to focus on reducing the burden of arthritis in the state. Her work included developing and expanding the arthritis program goals of collaboration, public education, surveillance, professional development and intervention. Immediately prior to her death in March of 2002, Sharon was honored by the Centers for Disease Control and Prevention (CDC) National Arthritis Program. She was presented with an award for *Outstanding Contributions to Training to Reduce the Impact of Arthritis and Other Rheumatic Conditions*. Her energy, dedication, professionalism and vibrant personality are sorely missed; her example sets a standard as a model for emulation.

Rhode Island State Arthritis Action Plan
2001-2005

Introduction

Rationale

Arthritis and other rheumatic conditions has become one of our most pressing public health problems, affecting an estimated 42.7 million Americans in 1998—nearly one of every six people. By 2020, 60 million Americans are projected to have arthritis.[1] In Rhode Island an estimated 24% of adults had arthritis in 2000.[2]

Arthritis is the leading cause of disability nationally, limiting daily activities for more than seven million U.S. citizens.[3] These alarming figures are compounded by the enormous costs that our nation bears for arthritis treatment, its complications and the resulting disability. These costs are estimated to be almost $65 billion – a figure equivalent to a national economic recession.[3] As the population ages, this problem will worsen unless prompt and responsible preventive action is taken.

It was imperative that a proactive planning process be initiated to outline an action plan to address arthritis at national and state levels. The US Centers for Disease Control and Prevention (CDC) initiated a national planning process with the National Arthritis Foundation (NAF) through the development of the *National Arthritis Action Plan: A Public Health Strategy*. The document lays out a vision and a framework for addressing the arthritis problem in our nation. In it, strategic initiatives for a coordinated public health approach to this escalating problem were identified. The Rhode Island Department of Health (HEALTH) also recognized the need for planning and sought assistance from funds made available to CDC through congressional appropriations for arthritis prevention and control.

In 1999, HEALTH announced the receipt of a planning grant from the CDC to address the burden of arthritis in Rhode Island. The grant supported a two-year planning process. Staff from HEALTH, The RI Office of the Southern New England Chapter of the Arthritis Foundation and The University of Rhode Island (URI) Gerontology and Physical Therapy Programs worked with members of the Rhode Island community to develop a comprehensive proposal to address the problem of arthritis in our state. The overall goal of the plan is to improve the quality of life among persons affected by arthritis.

Plan Development

Numerous individuals and agencies collaborated to develop the 2001 Rhode Island Arthritis Action Plan. The planning process brought together community members and representatives from a variety of agencies to identify and coordinate strategies to reduce the burden of arthritis in our state. Planning participants met for five meetings that culminated in a strategic planning forum. A draft was written outlining recommendations and sent out to those participants for initial comment and suggestions for revision. Contributions of all these individuals and organizations were crucial to the success of this initiative. Their ongoing participation to improve and protect the health of persons with arthritis will be critical to fulfillment of the plan. This plan is designed to be a dynamic document that will undergo periodic evaluation, revision and updating.

The Burden of Arthritis in the United States and in Rhode Island

The term arthritis literally means joint inflammation, but is often used to refer to more than 100 different diseases and conditions that affect joints, surrounding tissues and other connective tissues. Diseases or conditions falling under the broad label of arthritis can be characterized as inflammatory, degenerative, metabolic, or infectious. The most common forms of arthritis and rheumatic conditions are osteoarthritis, rheumatoid arthritis, fibromyalgia, lupus, gout and bursitis. (see figure 1) These conditions have a significant impact on an individual's quality of life. The term arthritis will be used herein this document.

Figure 1. Common Arthritis Definitions

Osteoarthritis (OA): The most common form of arthritis, most often affecting the hip, knee, foot and hand. Also called "degenerative joint disease," the degeneration of joint cartilage and changes in underlying bone and supporting tissues lead to pain, stiffness, movement problems and activity limitations.

Rhuematoid Arthritis (RA): Characterized by chronic inflammation of the joint lining, which may extend to other joint tissues and cause bone and cartilage erosion, joint deformities, movement problems and activity limitations. RA can also affect connective tissue and blood vessels throughout the body, triggering inflammation in a variety of organs, increasing a person's risk of dying of respiratory and infectious diseases. Symptoms include pain, stiffness and swelling of multiple joints.

Fibromyalgia: A pain syndrome involving muscle and muscle attachment areas. Symptoms include widespread pain through the muscles of the body, sleep disorders, fatigue, headaches and irritable bowel syndrome.

From: The National Arthritis Plan: A Public Health Strategy, 1999.

Impact on the Individual

The physical, psychological, social, and economic effects of arthritis present a significant burden for many individuals. The Centers for Disease Control and Prevention (CDC) reports limitations in daily activity for seven million Americans[3] as a result of arthritis, depriving people of their independence and disrupting the lives of family members and other caregivers. Physical effects on well-being include pain, loss of joint motion and fatigue, which often result in a decreased level of physical activity. This puts them at further risk for a variety of other diseases including heart disease, premature death, diabetes, high blood pressure, colon cancer, and overweight. Arthritis can also affect a person's psychological and social well-being causing stress, depression, anger, and anxiety as well as decreased community involvement, difficulties in school, work and sexual problems.

Economic Impact

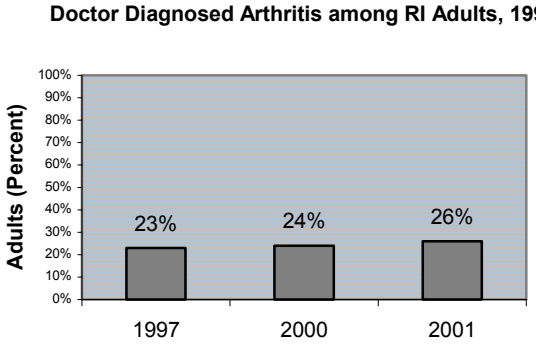
Economically, the implications of arthritis are significant. Arthritis is second only to heart disease as a major cause of missed work.[3] In addition to income loss from work limitation, other economic implications of arthritis include inadequate access to care and financial burdens due to health care costs. This cost is estimated to be almost $65 billion in direct expenses and lost wages, including an estimated medical bill of $15 billion for such expenses as 39 million physician visits and more than half a million hospitalizations.[3] Osteoarthritis (the most common form of arthritis) costs roughly three times that of rheumatoid arthritis, with over half of the costs incurred due to work loss.[4]

Data

The National Arthritis Action Plan: A Public Health Strategy (NAAP) identifies national estimates at 43 million persons affected by arthritis in 1998, with a projection of approximately 60 million affected by arthritis by 2020. Additionally, over seven million people in the U.S. are limited in their ability to participate in their main daily activities because of their arthritis.[3]

Prevalence

The Behavioral Risk Factor Surveillance System, (BRFSS) a random digit dial telephone survey conducted in every state, is one tool utilized by the CDC and HEALTH to provide a profile of health risks among adults and generate prevalence rates for arthritis. The BRFSS provides nationally standardized databases, allowing states to track health risks over time. In 1997, HEALTH included the first arthritis module in its state BRFSS survey. The results showed prevalence rates of doctor-diagnosed arthritis at 23.2% in the state.[5] That figure rose slightly to 24.2% in 2000[2] and 26% in 2001.[6]

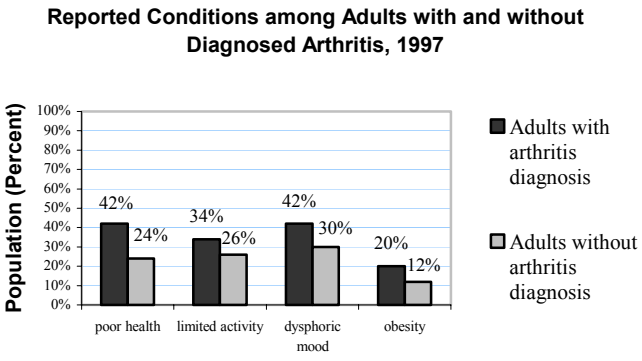


The prevalence of arthritis increases with age to about 35% of men over 65 and 59% of women over 65.[5] Population projections predict that both the number and the proportion of persons aged 65 and older will rise sharply both nationally and in Rhode Island, thereby increasing the prevalence of arthritis.[3]

No significant racial differences in arthritis prevalence were noted in the 1997 and 2001 RI BRFSS. Proportions of non-Hispanic whites and non-Hispanic blacks who have arthritis are similar. Fewer Hispanics than whites have arthritis, probably reflecting the younger age structure of the Hispanic population in the state. Prevalence of Asian and Native Americans was unavailable because of insufficient data for these groups in Rhode Island.[5, 6] National estimates from the National Health Interview Survey find Whites and African Americans having similar rates of arthritis, but African Americans reporting greater rates of activity limitation due to arthritis.[7]

Impact

The 1997 RIBRFSS results find that among Rhode Islanders with an arthritis diagnosis, more than 37% said they were limited in their activities as a result of their condition. Even after adjustments for age and sex, people with arthritis were much more likely than others to report poor health (42% vs 24%), limited activity (34% vs 26%),

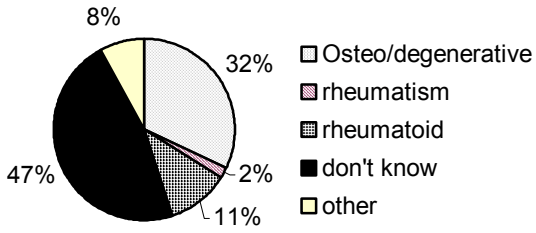


dysphoric mood (42% vs 30%), and to meet the criterion for obesity (20% vs 12%) over those without arthritis.[5] Additionally, the 2000 survey estimates that 38% of the adult population in Rhode Island experience pain, aching, stiffness and swelling of the joints within the past 12 months, with approximately 30% experiencing limitations as a result of their joint symptoms.[2]

Type

In 1997, an estimated 28% of Rhode Islanders with arthritis had osteoarthritis.[5] That figure rose to 32% in 2000. Additionally, that year 47% of persons with diagnosed arthritis do not know what type of arthritis they have, a similar figure to 46% in 1997.[2,5]

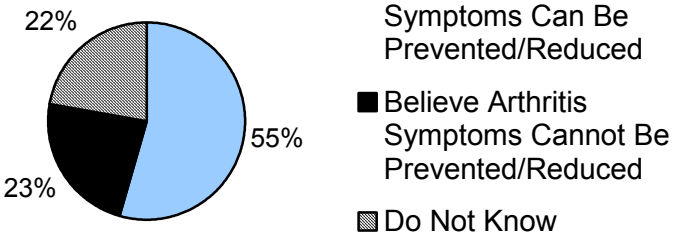
Types of Diagnosed Arthritis among Adults, 2000



Lifestyle Modifications

Less than half of the people with arthritis (36%) are currently being treated by a doctor for their arthritis, according to 2000 RI BRFSS figures.[2] The 2000 BRFSS also included a series of new questions developed to assess arthritis awareness and self-management behaviors among RI adults. This information will direct the development of effective health promotion programs and the interventions included in this Rhode Island Arthritis Action Plan. Preliminary data from the 2000 RI BRFSS data show only 54% of all RI adults think arthritis symptoms can be prevented or reduced. In addition, only a small proportion of people with arthritis see an arthritis specialist or has enrolled in self-help programs. Perhaps even more significant to the planning process is that many of those who are aware of the benefits of proper management strategies such as exercise and weight control do not practice these behaviors.[2]

Arthritis Beliefs among all RI Adults, 2000



Factors Affecting Arthritis Risk

A greater risk of arthritis is associated with certain factors. Non-modifiable risk factors (those that cannot be changed) include female gender, advanced age and genetic predisposition. Modifiable risk factors (those that may be changed/prevented) include physical activity levels, obesity, joint injuries, infections and certain occupations such as those with repetitive knee-bending or other repetitive joint movements. Awareness of these risks is important in order to identify groups at higher risk and effectively target intervention efforts.

Non-Modifiable Factors:

- Female Gender: Women aged 15 years and older account for 60% of all arthritis cases.[3] In 1995, it was reported that at least 26.4 million U.S. women have arthritis, listing it as the leading chronic condition among women. An estimated 36 million women will be affected by arthritis by 2020.[8]

- Advanced Age: Older age is associated with an increased risk of arthritis as half of all adults 65 and older are affected by arthritis.[3]

- Genetic Predisposition: Genetic predisposition is known to affect risk for certain types of arthritis. The exact role of these genetic factors is still unclear, but there is evidence that certain genes are known to be associated with a higher risk of some types of arthritis. Rheumatoid arthritis, ankylosing spondylitis, and lupus erythematosus are most associated with a genetic influence.

Modifiable Factors:

- Activity Levels: Physical inactivity can complicate the problems associated with arthritis. Pain from arthritis can lead to a failure to use the affected joints, which in turn can lead to muscle atrophy, as well as joint capsule and tendon contracture. The result is decreased flexibility and ultimately a loss of independence. Regular, moderate physical activity helps maintain joint health and can improve aerobic capacity and alleviate depression.[3] Studies have also shown that an appropriate exercise program will help reduce pain and improve functional capacity in people with osteoarthritis.[9]

- Overweight and Obesity: Obesity and overweight increases the risk of arthritis, especially osteoarthritis of the knee and hip. Conversely, weight loss has been shown to be effective in the management of arthritis. A weight loss of 5 kg (approximately 11 pounds) is associated with a 50% decrease in the risk of developing symptomatic knee osteoarthritis.[4]

- Other: Infection, injuries and occupational injuries are other risk factors for arthritis. Primary prevention aimed at preventing Lyme disease, carpal tunnel syndrome and injuries to the joints can reduce the prevalence of arthritis.

A Public Health Approach to Arthritis in Rhode Island

The Rhode Island State Arthritis Action Plan is modeled after the *National Arthritis Action Plan: A Public Health Strategy*. The ultimate aims of this initiative are to:

- Increase public awareness of arthritis as the leading cause of disability and an important public health problem.
- Prevent arthritis whenever possible.
- Promote early diagnosis and appropriate management for people with arthritis to ensure them the maximum number of years of healthy life.
- Minimize preventable pain and disability due to arthritis.
- Support people with arthritis in developing and accessing the resources they need to cope with their disease.
- Ensure that people with arthritis receive the family, peer, and community support they need.

Figure 2
Healthy People 2010 Objectives
Arthritis and Other Rheumatic Conditions

2.1	***Increase the mean numbers of days without severe pain among adults who have chronic joint symptoms.***
2.2	***Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.***
2.3	***Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.***
2.4	***Increase the proportion of adults aged 18 years and older with arthritis who seek help in coping if they experience personal and emotional problems.***
2.5	***Increase the employment rate among adults with arthritis in the working-aged population.***
2.6	***Eliminate racial disparities in the rate of total knee replacements.***
2.7	***Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms.***
2.8	***Increase the proportion of persons with arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.***

From: The Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH).

Goals

The overall goal of the Rhode Island Arthritis Action Program is to stimulate and strengthen a statewide, coordinated effort for reducing the occurrence of arthritis and its accompanying disability. Specific goals include:

- Increase awareness of arthritis, its impact, the importance of early diagnosis and appropriate management, and effective prevention strategies.
- Support and contribute to a solid scientific base of knowledge for the prevention of arthritis and related disability.
- Implement effective programs to prevent the onset of arthritis and its related disability.
- Achieve the arthritis-related objectives included in *Healthy People 2010*.[7] These objectives identify benchmarks of success for measuring improvements in health and quality of life. (see figure 2)

Action Framework

The Rhode Island Arthritis Action Program (RIAAP) adopted an action framework that mirrors the framework of the *National Arthritis Action Plan: A Public Health Strategy (NAAP)*. This framework encourages adherence to NAAP's key values of emphasizing prevention, using and expanding the science base, seeking social equity and building partnerships.

The framework proposes activities in three major areas:

- Surveillance, epidemiology and prevention research
- Communication and education
- Programs, policies, and systems

These areas of focus are part of a comprehensive public health plan that emphasizes three levels of prevention using a population-based approach, in contrast to the medical model that focuses on the individual. For arthritis, specific prevention strategies have been identified to reduce the burden of arthritis in the population.

Primary prevention strategies – those that are designed to prevent a disease or condition from occurring – are somewhat limited in relation to arthritis. Strategies that are considered to be effective include:

- **Weight control**. A healthy weight lowers an individual's risk for certain types of arthritis including osteoarthritis of the knee in women and gout in men.[3]
- **Occupational injury prevention**. Prevention of traumatic joint injury and repetitive use injury can help prevent arthritis.
- **Sports injury prevention**. Joint injury prevention strategies such as proper warm-up, muscle stretching and strengthening exercises can help lower the risk of osteoarthritis.[9]
- **Infectious disease control**. Prevention of Lyme disease and other infectious arthritis conditions can help limit these types of arthritis.

Secondary prevention strategies – those that reduce the impact of the disease by providing for early diagnosis and treatment include:

- **Early diagnosis.** Early diagnosis of arthritis needs to be a focus of intervention strategies especially when considering the large numbers of persons that fail to see a physician for their arthritis despite activity limitation.
- **Medical treatment.** Prompt, effective treatment for arthritis can help to ameliorate the effects of the disease. Examples of this include prompt treatment of gout and Lyme disease, or the use of disease modifying anti-rheumatic drugs for rheumatoid arthritis.

Tertiary prevention strategies – those that improve the quality of life for persons with arthritis by focusing on reducing the consequences of a disease once it has developed. Strategies that help prevent complications and disability in arthritis include:

- **Self-management.** Weight control and physical activity are two components of a self-management program for the following reasons:

1. Physical activity helps maintain joint health and can improve aerobic capacity and alleviate depression.[3]
2. Obesity is associated with increased risk of osteoarthritis and puts additional stress on joints.[4]
3. Education regarding self-management strategies has been shown to be effective in reducing arthritis pain and associated costs.[3]

- **Rehabilitation.** Therapies that strengthen muscles, protect joints, manage pain and modify activities can serve to preserve independence, encourage self-management and promote wellness.
- **Medical and surgical treatments.** Medications can reduce the effects of the disease by limiting disease progression, controlling symptoms and preventing serious complications. Joint replacement has been found effective for those most severely affected.

Rhode Island's Plan for Action:

The following plan for action is the culmination of numerous planning meetings of the Arthritis Planning Council. It is provided as an ***outline*** of objectives and suggested actions for the Rhode Island Arthritis Action Program. As interested partners come together to work to reduce the burden of arthritis in the state, the activities and strategies will be continually reviewed and revised to make sure appropriate interventions are developed.

This is a working document. Annual meetings to review objectives and to propose actions/strategies will be held to keep this document updated and useful.

Rhode Island's Plan for Action to Reduce the Burden of Arthritis

Focus Area: Surveillance, Epidemiology and Prevention Research

Surveillance	Epidemiology	Prevention Research
The ongoing and systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice.	The study of the distribution and determinants of health-related states or events in specified populations and the application of this study to the control of health problems.	The development and evaluation of interventions designed to prevent onset of or disability from a health problem or condition.

Goal: To seek better scientific information and disseminate the information to the appropriate populations.

Objectives:
1) To sufficiently describe the burden of arthritis in Rhode Island.
2) To analyze and report on the impact of various risk factors for arthritis
3) To analyze and report on the effectiveness and impact of education, prevention and treatment programs on the burden of arthritis.

Actions	**Data Sources**
• Define "arthritis" and "chronic joint symptoms" for public and policy makers. • Survey existing sources of data to evaluate knowledge, gaps, barriers, strengths and weaknesses related to arthritis in Rhode Island. • Collect, analyze, and disseminate findings from Behavioral Risk Factor Surveillance System (BRFSS) arthritis and quality of life modules. Further develop and improve state-specific modules. • Utilize data as part of the evaluation plan to monitor progress and identify gaps in the Rhode Island Arthritis Action Plan. • Incorporate education in survey systems. • Track response to and use of educational efforts. • Disseminate data to public and key partners (assure for non-English speaking audiences) • Create a workgroup to create a data analysis plan. • Development of Arthritis edition of RI Medicine and Health. • Find additional sources of funding including • Link data to health care costs	• BRFSS – both national and state-specific modules • Physician/Provider Survey including issues related to knowledge and practice patterns • Web site tracking • Baseline Surveys • Focus Groups • Key informant interviews • Surveys of Community Based Organizations • Hospital Discharge Data • Clipping service • Hospital Chart reviews • Survey of Managed Care education efforts • Arthritis Foundation statistics • Arthritis Foundation education and physical activity program data

Focus Area: Communication and Education

Communication	Health Education
The effective transmission of a message from the sender (public health) to the receiver (the general public, people affected by arthritis, and health professionals). Health communication strives to increase awareness to lay the groundwork for behavior change.	Organized learning experiences that facilitate knowledge, attitudes, and voluntary behavior changes conducive to health on both the individual and community/system levels. Health education encompasses the entire spectrum of behavior change.

Goal: To increase awareness of arthritis and effective strategies for prevention and treatment. The focus area of communication and education centers on three target populations - the general public, people affected by arthritis, and health professionals.

Objectives for general public and people affected by arthritis:

1) Develop and disseminate appropriate messages
2) Identify resources to develop programs and services
3) Increase collaboration within the state

Objectives for Health Care Professionals:

4) Develop resources to assist in program development
5) Improve the knowledge, attitudes and practices of practitioners

Objective 1: Develop and disseminate appropriate messages

Focus/Aim	Actions	Venues
• Increase awareness • Dispel myths • Educate throughout the lifespan • Advocacy • All levels of prevention: primary, secondary and tertiary (especially weight management and physical activity) • Early diagnosis and appropriate management to prevent disability.	• Survey existing media and educational materials and revise as needed. • Develop culturally appropriate materials for specific populations. • Target specific age groups. • Target workplace education re: disease and rights of persons with arthritis. • Utilize social marketing strategies. • Piggyback to other dissemination venues. • Develop "tool kit" for program planners. • Develop clearinghouse of information for workplace education. • Development of state Department of Health arthritis web page. • Utilization of residents with arthritis as spokespeople	• Schools • Senior Centers • Centers for Independent Living • Libraries • Hair Salons • Women's Organizations • Workplace Wellness Programs • Agency Newsletters • Web sites • Talk shows/Radio and TV spots • Community based organizations • Worksite Wellness Council of RI • Health insurers and Managed care organizations • Faith-based and civic organizations • Traditional Media outlets

Objective 2: Identify resources to develop programs and services

Focus/Aim	Actions	Venues
• Fully utilize existing resources • Avoid duplication of services • Fill identified gaps • Use Healthy People 2010 goals as a guide	• Identify existing resources. • Identify gaps in existing resources. • Develop a community based "guide." • Develop clearinghouse of available resources	• Community based organizations • Student internships • Diversity settings • Chambers of Commerce

Objective 3: Increase collaboration within the state

Focus/Aim	Actions	Venues
• Involve a variety of health professionals and community members • Community focus	• Develop collaboration/coalition of various agencies involved with seniors and those with arthritis. • Form a committee to initiate coalition-building measures. • Participate in Paths to Health/Walk with Ease collaborative efforts.	• Schools (including universities and medical schools) • Senior Centers • Centers for Independent Living • Libraries • Workplace • Community based organizations • Professional organizations • Other chronic disease, disability and health promotion programs

Objective 4: Develop resources to assist in program development

Focus/Aim	Actions	Venues
• Development of available resource directory for providers regarding clinical guidelines for disease management and referral sources for consumers.	• Identify gaps in resources (local and national). • Survey existing materials for professional education (update as needed). • Develop "tutorial" program links to other sites. • Obtain evaluation data; pre- and post- (e.g. attitudes and changed practices). • Work to close gaps. • ID and disseminate clinical guidelines • ID/develop and disseminate consumer education to be delivered by health care professionals	• Print • Electronic Website • Media • Medical Rounds • Professional education programs • Calendar/bulletin board.

Objective 5: Improve the knowledge, attitudes and practices of practitioners

Focus/Aim	Actions	Venues
• Development of a teamwork philosophy. • Content scope to include non-traditional and non-medical treatments. • Nurture/mentor/educate health professionals to "vision" of Rhode Island Arthritis Action Plan. • Improve referral to physical therapy • Shift medical culture from “illness” to “wellness”	• Utilize existing Continuing Education (CE) mechanisms. • Develop interdisciplinary team for outreach development to provide education at professional meetings. • Participate in annual professional conference booth displays and presentations. • Partner with Brown medical school. • Develop module for residency training. • Specific educational courses (more intensive than continuing education with more selected participants). • Utilize web-based education, existing websites. • Identify key MD's/NP's and work to develop collaborative efforts. • Create arthritis-edition of RI Medicine and Health • Identify resources to sustain education efforts	• Universities and medical schools • Grand Rounds. • Web Site two-way information flow • Professional list serve updates • Instant message • Tutorial. • Medical Society Journal. • Flyers to primary providers. • "Detail" visits to practice settings • Professional Association meetings • Higher Education conferences

Focus Area: Programs, Policies and Systems

The focus area of Programs, Policies and Systems centers on social systems at the local and state levels that work to promote increased quality of life for people with arthritis and facilitate prevention measures. These systems must provide a continuum of health services that bridge medical, voluntary and public health agencies and include primary, secondary, and tertiary prevention. Supportive policies need to be in place to establish an environment conducive to preventive efforts. It is essential that community norms promoting prevention and improved quality of life and a well-trained public health workforce be in place to promote these efforts.

Programs	Policies	Systems
The implementation of specific effective interventions for primary, secondary, and tertiary prevention.	Include legislation, regulations, ordinances, guidelines, and norms that establish an environment conducive to prevention.	The health infrastructure required to operate and manage effective prevention programs.

Goal: To establish a political and social infrastructure in Rhode Island that supports reducing the burden of arthritis in the state and has the capacity to assure the promotion of improved quality of life for those affected by arthritis.

Objectives:

1) To encourage systems that can provide the infrastructure to develop and deliver evidence based arthritis programs.
2) To encourage policy makers to develop and implement policies which reduce the burden of arthritis in Rhode Island.
3) To establish and convene a statewide Arthritis Advisory Committee.

Objective 1: To encourage systems that can provide the infrastructure to develop and deliver evidence based arthritis programs.

Focus/Aims	Actions	Venues
• Assuring a well-trained workforce to provide essential arthritis-specific programs • Enhance professional development • Sustained programs through worksites and other stable mechanisms	• Identify/provide resources for professional development • Identify large employer bases which can provide programs • Approach State as largest employer • Establish a 1-800-ARTHRITIS info line and/or refer to the Arthritis Foundation, Southern New England Chapter help line	• Worksites • Professional organizations • Specific target populations • Health care facilities • Parks and Recreation • Unions • Medicaid • Medicare

Objective 2: To encourage policy makers to develop and implement policies which reduce the burden of arthritis in RI.

Focus/Aims	Actions	Venues
• Get arthritis on the "radar screen." • Translate data to appropriate target audience – employers, legislators, planners, etc. • Expressing burden of arthritis beyond data numbers • Arthritis reimbursement	• Set policy agenda. • Enlist advocacy spokesperson. • Enlist support of health care plans/insurers. • Develop series of periodic mailings to providers and policy makers. • Collaborate with Universities, graduate programs, research and intervention. • Collaborate with rehabilitation programs and community based organizations. • Participate in Arthritis Awareness month (May) activities. • Collaborate with other chronic disease initiatives such as osteoporosis, obesity, diabetes. • Develop public advocacy programs. • Advocate to include HEDIS/QI measures that address arthritis	• Managed Care Organizations • Medicaid and Medicare • Health care professional periodicals/newsletters • Health care providers • Legislative communications • Medical office managers • Seniors Centers, High Rises, Malls • Community Arenas (Churches, Beauty Salons, Barber Shops, Garden Clubs, Country Clubs and other unique settings) • Municipalities – town planners, zoning, etc. • Worksite Wellness Council of RI • Health care facilities • Transportation (DOT, RIPTA, etc) • Assisted Living • Parks and Recreation • Governor's Commission on Disabilities

Objective 3: Establish and convene a state-wide Arthritis Advisory Committee

Focus/Aims	Actions
• Professional development • Advocacy • Policy Development. • Research and development (translating practice to cost). • Consumer/community input	• Survey resources for gathering and disseminating information. • Develop and disseminate health/provider resource list. • Assessment and benchmark identification. • Establish committee (use RI Diabetes Coalition as a model). • Meet on a regular basis – probably quarterly. • Must be inclusive public, private agencies, worksites, community, health care providers and consumers, etc. • Coordinate through the Department of Health. • Draw upon expertise at other federal and state levels.

References

1. "National Arthritis Month – May 2000," Morbidity and Mortality Weekly Report, May 5, 2000, Vol. 49, No. 17, pg 365.

2. Rhode Island Behavioral Risk Factor Surveillance System, 2000, Office of Health Statistics, Rhode Island Department of Health, and supported in part by the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention Cooperative Agreement U58/CCU100589-1-17 (1990-2002).

3. "National Arthritis Action Plan: A Public Health Strategy," Arthritis Foundation, Association of State and Territorial Health Officials, Centers for Disease Control and Prevention, 1999

4. Felson, David T., and Yuqing Zhang, "An update on the epidemiology of knee and hip osteoarthritis with a view to prevention," Arthritis and Rheumatism, Vol 41, No. 8, August 1998, pp.1343-1355.

5. Rhode Island Behavioral Risk Factor Surveillance System, 1997, Office of Health Statistics, Rhode Island Department of Health, and supported in part by the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention Cooperative Agreement U58/CCU100589-1-17 (1990-2002).

6. Rhode Island Behavioral Risk Factor Surveillance System, 2001, Office of Health Statistics, Rhode Island Department of Health, and supported in part by the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention Cooperative Agreement U58/CCU100589-1-17 (1990-2002).

7. "Healthy People 2010, Chapter 2: Arthritis, Osteoporosis, and Chronic Back Conditions," Centers for Disease Control and Prevention & National Institutes of Health

8. "Prevalence and Impact of Arthritis among Women – United States, 1989-1991, " Morbidity and Mortality Weekly Report, May 5, 1995, Vol. 45, No. 17, pp: 329-334

9. "Physical Activity and Health: A Report of the Surgeon General," US Department of Health and Human Services, Centers for Disease Control and Prevention & The Presidents' Council on Physical Fitness and Sports, 1996